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ABSTRACT

The report of a team project concerned with idea development for community mental health centers includes--(1) concept description, (2) development of facility and resource requirements, (3) conceptual diagrams, (4) schematic plans, and (5) model photographs. (MH)

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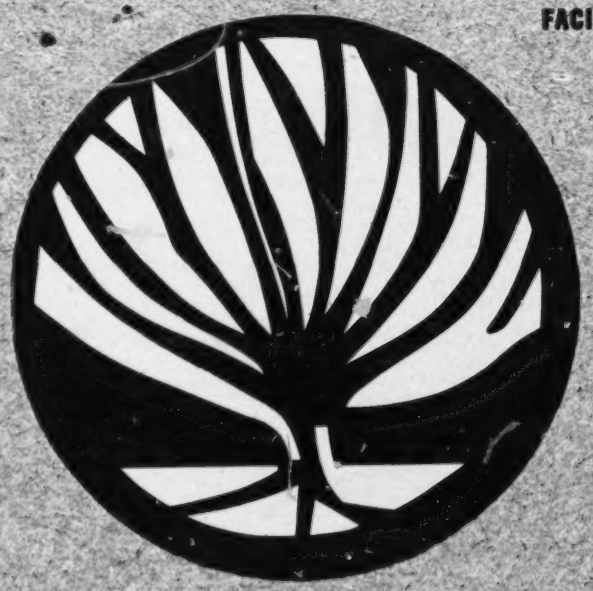
THE BRIDGE - A REPORT ON MENTAL HEALTH FACILITIES FROM CAUDILL ROWLETT SCOTT



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INVESTIGATIONS

by

CAUDILL ROWLETT SCOTT

ARCHITECTS PLANNERS ENGINEERS

CRS has always been research minded. This attitude stemmed from close association with the Texas Engineering Experiment Station, as far back as 1946.

In 1952, the firm began sharing its research reports. This series was called "research-architecture." In 1954, CRS was commissioned by the American School and University to prepare a second series of "Research Reports." These reports were widely distributed in the hope of improving schoolhouses of America. A third series called INVESTIGATIONS was initiated in 1960.

This report is one of the latest series. Some of these INVESTIGATIONS involve actual research, while others represent current thoughts of some CRS staff members. There will also be times when guest professionals are brought in to contribute to the series. INVESTIGATIONS will cover various areas of architecture.

CRS hopes that this report will in some small way help our clients and professional friends achieve a better environment for themselves and their neighbors.

Early in June of 1965 at Rice University a group of architects, psychiatrists and advanced architecture students from all over the United States participated in a ten-day conference. The purpose of this Rice Design Fete, sponsored by the National Institute of Mental Health, was to develop new ideas for mental health centers and to stimulate thought among people responsible for the development of such community facilities. The group was divided into six teams, each team consisting of an architect, two psychiatrists, and five students.

"The Bridge" is the final report made by the team which was headed by Architect Bill Caudill of Caudill Rowlett Scott, Architects, Engineers, Planners; Alfred Paul Bay, M.D., Superintendent, Topeka State Hospital, Topeka, Kansas; and Matthew P. Dumont, M.D., Massachusetts General Hospital, Boston, Massachusetts.

Rice University will soon publish the results of the entire Design Fete. This is an unabridged version of "The Bridge."

Jan Talbot
Editor of the Series
January, 1966

Behind the hedges ...

and far beyond the mainstream of daily community life

are situated most of the mental health facilities

in the United States.

Such facilities are not easily accessible

to the one in ten American citizens

who now need psychiatric care

for mental or emotional illness.

Our vast, custodial state institutions too frequently

receive patients only after the illness has reached

a state of crisis.

In such institutions

overcrowding and the complete disassociation of the patient

from his normal environment

may make his confinement debilitating and lengthy.

Mental health concerns the well and the sick.

The community mental health center can be situated

within the mainstream of normal daily American life.

Inviting and easily accessible to all comers,

the center can help check disorders

before the crisis stage is reached.

The community mental health center

can help to shape community attitudes

toward the program.

It is a statement of togetherness with the community,

and a force within the community

for all who will seek help.

It should not be placed apart

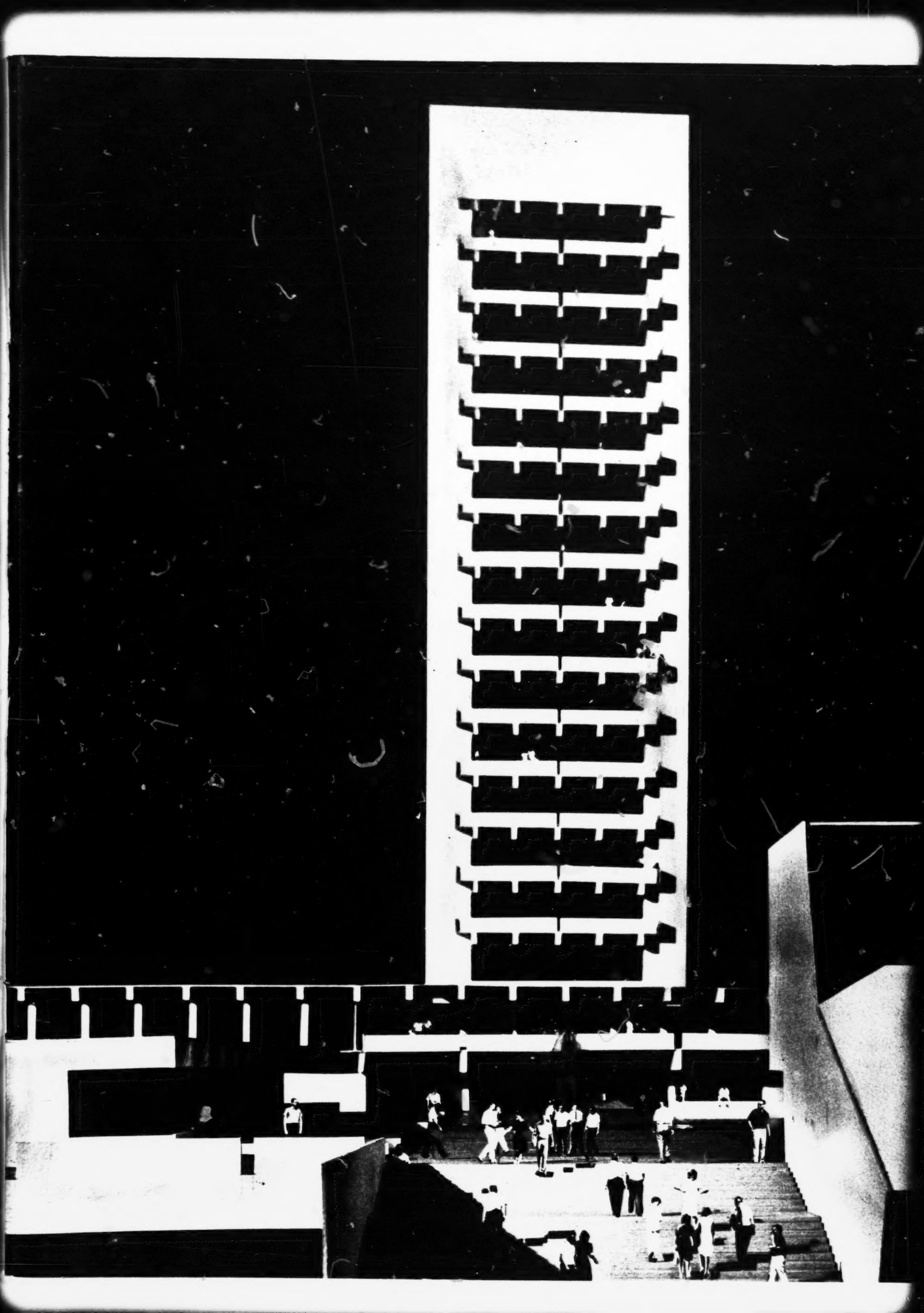
from the community it is to serve . . .

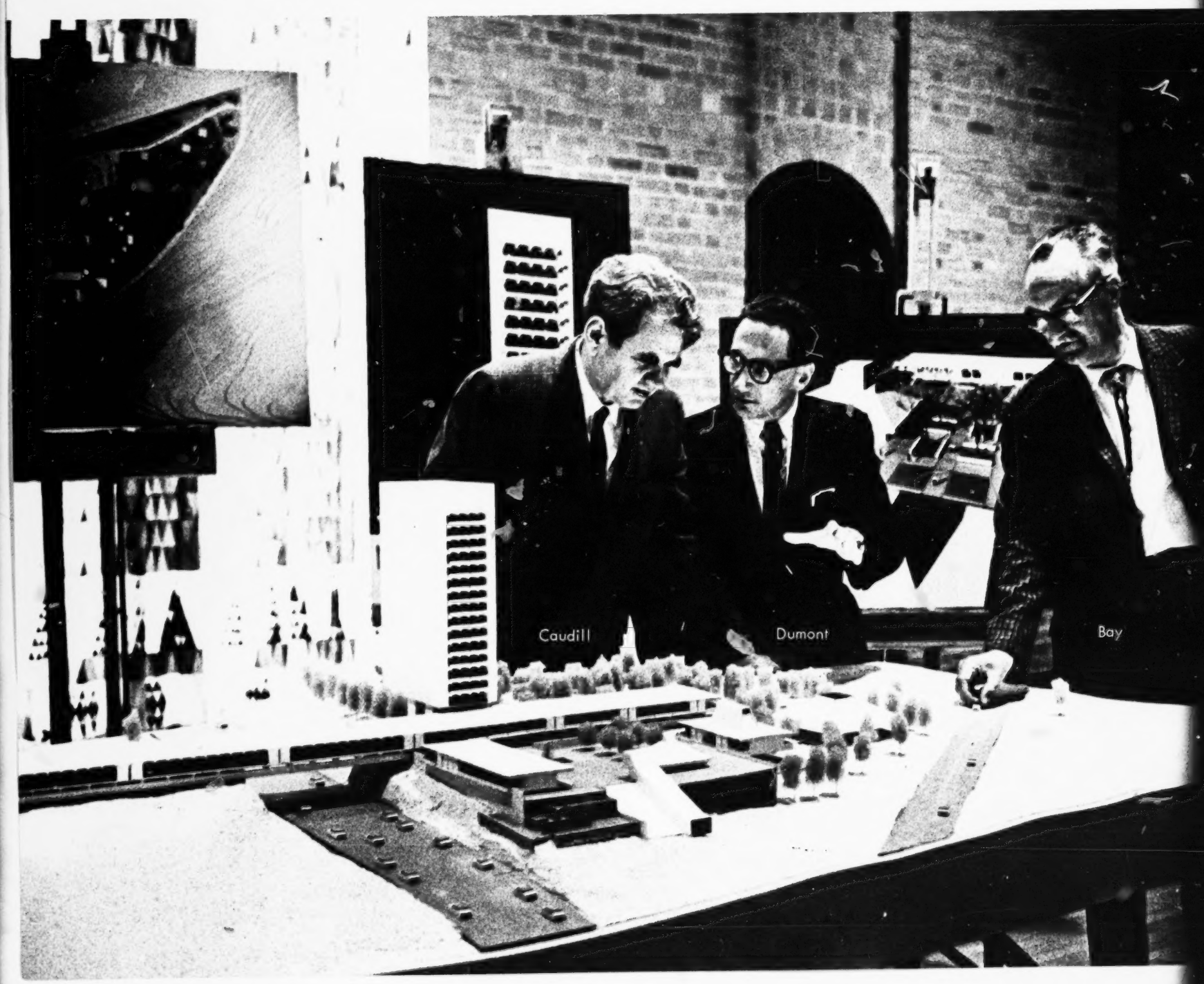
it must not be the point of last resort . . .

behind the hedges.

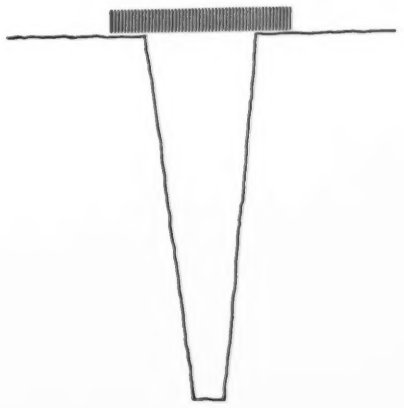
James Falick

James Falick, AIA
Health Facilities Division
Caudill Rowlett Scott




Caudill
Dumont
Bay

THE BRIDGE



Alfred Paul Bay, MD
Matthew Dumont, MD
William W. Caudill

We see in the Northwest Baltimore Mental Health Center the opportunity to meet a great civic need beyond the mere provision of treatment to the mentally ill. The sponsoring agency has already manifested its willingness to undertake a broader responsibility by such proposals as a nursery school for children of hospitalized mothers, by a nursing home, and by a convalescent home for children. Here is the opportunity to go a giant step further.

The site is favorable to the development of a broadly based demonstration and teaching center for the fuller, happier, and healthier life. The elements of such a center — not frequently mentioned as part of a community mental health center, but certainly appropriate to the prevention of emotional disa-

bility — could include such elements as (1) the nursery school where healthy habits of learning and expression could be inculcated, (2) the "educational node" for adults, (3) the sheltered workshop-sheltered living center with special housing units for Synanon, Alcoholics Anonymous, Halfway House, and physically handicapped and a place where each of these might earn a record of productive work experience (besides a modest grubstake), and (4) a recreational center.

The mental health activities themselves could then be located in a most logical position — on a bridge which would testify in a most dramatically symbolic way to the intermediate position of the mental health center between the hospital on the one hand and the productive, happy, growing, and learning community on the other; between illness on the one hand as opposed to buoyant health.

APPROACH

At the outset of our association, we found at least two possible ways to approach the requirement of our client. The first would be to limit the elements to be included in our solution to those which the Sinai Hospital or the National Institutes of Health had already acknowledged as possibilities. This position was abandoned by immediate consensus in favor of the idea that we had an obligation to suggest logical relationships between our immediate program requirements and other naturally related social goals. Therefore, although we knew that the ultimate

beneficiary of the services which our facility is to provide is the individual patient, we began by enunciating rather global principles about people in groups.

The first of these emerged quickly upon our contemplation of the site; the need to dispose our services on two hills separated by a depressed trafficway suggested a physical bridge and the obvious symbolism of the mental health center as a figurative bridge between illness and health.

Another early and fundamental observation was that in the Northwest Baltimore area no facility designed exclusively to provide mental health services would succeed in reaching all of the disparate ethnic and socio-economic groups populating the area and enticing them to use it. To us, the consequence of this conclusion was that we gave considerable attention to any feature which would contribute to the appeal of the central facility as a place where people might congregate willingly. We felt that the teeming, low income population in the southeast corner of the catchment area would have to be served by organizational structure rather than architectural structure. Physical representation of that notion is confined to the planning office and the switchboard from which travelling teams, storefront clinics, and the like would be deployed.

Throughout, our design avoids dictation of detail in interior spaces; we have reserved these decisions for the actual client.

PHILOSOPHY

The truly comprehensive mental health center, as a bridge between illness and health, between hospital and community, must do more than provide a coordinated spectrum of treatment facilities to modify an illness. It must assume a responsibility for the prevention of mental disorders and the rehabilitation of those who will forever be afflicted with them. Unlike organic disease, mental illness never completely resides in the individual. The ability to adapt to the stresses of the human condition must be seen in terms of a balance between the innate emotional strength of the individual and the stability of the social system in which he operates.

In the metropolis, with its pockets of poverty and racial strife, its physical decay and improvident renewal, the individual's capacity for adaptation is frequently strained to the breaking point. The urban mental health center, in order to fulfill its preventive and rehabilitative as well as its treatment responsibilities, must, then, become an agency of total concern for the well-being of the city dwellers it serves. The Sinai Mental Health Center will exist in an area of middle class comfort and stability but includes in its catchment area a corner of blight, unemployment, transience, and segregation. Predictably, it is that corner which has the highest state hospitalization rate in the area. It is basically this southeastern corner that is most in need of the services of a mental health center and yet is farthest removed from it.

This was the first bridge that had to be built. How do you bring a working class Negro population with its diffidence and hostility to a psychiatric facility in a white, middle class neighborhood? Our solution was to create a recreational, educational, and welfare complex as an urban oasis that will attract the initial population. The means that are used to bring the patient to the treatment facility will themselves be a major force for primary prevention.

The location of the major psychiatric diagnostic and treatment facilities on a bridge is not merely the result of a topographic contingency. Admission to a psychiatric unit is frequently perceived by the patient as a sign of hopelessness and defeat. When the unit is literally a span between a general medical facility and a complex of community oriented services, the patient can never forget that movement is inevitable.

ADMINISTRATION

The administrative functions of the center will be primarily those of planning, coordinating, and budgeting. Fund raising, collections, billing, accounting, purchasing, supply, housekeeping, maintenance, food services, and laundry will be provided through the appropriate office of the general hospital with a few notable exceptions: the "Industrial Village" will be largely autonomous as far as food service and housekeeping are concerned; the tea garden, the beer garden, the cafe-theater will probably be concessions. Personnel processing, except for selection of professional personnel, will also center in the general hospital's personnel office.

The administrative area is the "front door" or "main gate" for the prospective patient-clients. Therefore, it has the following components:

1. A Patient Service Component of waiting room, receptionist, triage social worker, and an "officer of the day" (to handle emergency calls or interviews on a day and night basis).

2. Communications Component, including a switchboard, mail clerk, typing pool, and record center for individual case files, program reports, statistical accumulation, and program analysis.

3. Planning Component, including Director of Program and secretary, Director of Information and Community Education and secretary, Director of Research and Professional Education and secretary, and conference room.

4. Urban Studies and Planning Center
   sociologists, anthropologists, ecologists, etc.....20 offices
   architects — design and engineering.....10 offices
   loft

EMERGENCY

A major functional component of the Community Mental Health Center is the constant and immediate availability of psychiatric consultation to the emergency ward and medical-surgical services of the hospital. Because so many psychiatric emergencies initially identify themselves in organic terms (e.g., the suicidal patient who has ingested pills or lacerated himself, the hysterical patient who "cannot breathe," the anxious patient who fears a heart attack, etc.) it is crucial that the emergency psychiatric facility be completely integrated within the general emergency ward of the hospital.

CONSULTATION

If the medical and surgical services of a general hospital are to be concerned with human beings who are ill rather than with diseased organic systems, they must be able to rely on psychiatric consultants. The withdrawn patient with cancer, the depressed woman who has just delivered a baby, the agitated and confused patient after cataract surgery, the demanding and cantankerous man who has had an amputation — these and many more are the appropriate subject matter for a psychiatric consultation.

Much of the psychiatric involvement on these services will be staff-oriented (particularly the intensive care and rehabilitation wards), but whether the problem is in the patient or the staff or both, the consultation response must be rapid if not actually anticipated. This service, like the emergency psychiatric facility, has no structural definition. All that is required is the consultant and a page system. This intervention cannot carry the burden of the psycho-analytic model with its upholstered fifty-minute hour.

24-HOUR INPATIENT SERVICE

This will provide a twenty-four hour total care facility for twenty patients who will have an average stay of two weeks and a maximum stay of three weeks, thus providing a population of some 2,000 patients with an evaluation and intensive care facility within a community mental health center.

There will be twelve single rooms and four double rooms in this complex. The single rooms will provide 110 square feet per patient and the double rooms will provide 90 square feet per patient. Each patient will have a total living space (which includes his bedroom) of 300 to 500 square feet per individual.

Five of the single bedrooms, though not being readily identifiable as maximum security rooms, will be placed in such a way (at the end of a corridor with a nurses' station nearby) that a patient will not easily be able to escape or do himself very much harm without interruption. All of the rooms can be locked from the outside, however, and detention screens, looking like ordinary screens, will be on all windows.

The living space for the patients will include areas for dining, TV viewing, reading, and ward group functions, therapy and otherwise. These may be broken down as desired by the architects so that the living area may also function as a group activity area or TV viewing area, but it would be desirable to have some division between a TV viewing area and a small group or reading area.

There need not be a separate Occupational Therapy shop, but an alcove off one of the living areas can be used, as can such an alcove for a domestic laundry area. There need be no nursing

station, per se, but a locked, small, 2' x 2' area for drugs will be necessary. A small kitchen, opening onto the living space, for patients to use as they wish would be desirable. Two interviewing rooms, one of which will be large enough to include an examining table, will be necessary.

A conference room of about 225 square feet for medical conferences, nursing reports, and records will be necessary.

There will be four bathrooms, two male and two female.

ALCOHOLIC PROGRAM

We see the treatment of the alcoholic as being divided into several segments: 1) the "wet" alcoholic, 2) the "dry" alcoholic, and 3) the "damaged" alcoholic.

1. The "Wet" Alcoholic: his treatment is essentially a medical problem, the process of detoxification, of drying out. The process is carried on in bed by professional medical and nursing staff, which dictates the location of such a unit as close as possible to neuromedical and neurosurgical areas, laboratories, etc. The process usually is brief — three to six days. The unit, therefore, may be small.

2. The "Dry" Alcoholic (not presently intoxicated): his treatment depends, in high degree, upon self motivation and is, therefore, best conducted in an outpatient setting or else in a special domiciliary unit for alcoholics where he may participate in both government and maintenance of his own care.

3. The "Damaged" Alcoholic: this is substantially a case of organic brain deficit, and if the deficit is sufficient it may require custodial care in a nursing home or state hospital.

OUTPATIENT CLINIC

For many patients, hopefully for most, the Outpatient Clinic provides the first screening process, the first evaluation of the present problem. Diagnosis, appraisal, and disposition is, then, one of its most important functions. Where the disposition is to another service, the Outpatient Clinic's duty is ended. However, the problems of a large number of patients turn out to be answerable to outpatient treatment. Such treatment may include prescription of drugs, psychotherapy — individual or group — and family case work.

DAY CARE & EVENING CENTER

To demonstrate its function as a mode of care transitional between full hospitalization and community living, the center will be a distinct unit "across the bridge."

Between 9:00 a.m. and 5:00 p.m., it will be a Day Care Center, and between 5:00 p.m. and 9:00 p.m., it will be an Evening Center, the patients being different for the two centers but under the same administrative and staff management. Patients may have been transferred from another unit or have been admitted directly.

At any one time, the Day Care Center will accommodate thirty patients, but as some patients will be coming only a half day once a week and others will be coming five full days a week, more than one hundred patients may be in treatment in the center at any one time. A limit of three months may be placed

on the entire treatment of a patient in the Day Care Center. The Evening Center can accommodate twenty patients at any one time, but, again, individual attendance will vary from one to five times a week.

The combined operation can treat as many as one thousand patients per year.

The total space of the center will be 40' x 80'. There will be four quiet rooms with couches for napping or being alone — each room 10' x 10'. An Occupational Therapy area will be 10' x 10'. A kitchen, 10' x 20', will be a center for much activity as both day and evening patients will be expected to prepare their own meals on a rotation basis. The kitchen should open onto a dining or snack area and should be near the large outside patio which will be used for barbecues or outside dining. A reading and conversation room away from the TV set will be 10' x 20'. The nursing station and record area can be 10' x 10'. A doctor's interviewing and examining room can also be 10' x 10'. The remainder of the space, with ping pong and bridge tables and lounge furniture, can be used for a large group meeting that will be a major therapeutic activity.

EXTRAMURAL PROGRAMS

There are no walls around the community mental health center. We have attempted to attract a needful population to an environment for the enhancement of life which incorporates clinical

facilities. This operation must be a two-way bridge. As it is necessary to bring the community to the center, it is necessary to bring the center to the community. This will be accomplished with a network of consultation services that will include contact with schools, settlement houses, probation and police officers, private physicians, trade unions, etc.

PTA's, teachers, and school principals can be taught something about mental illness and may bring individual or group problems to the attention of a consultant.

Settlement houses can have regular sessions with a psychiatric consultant who will augment their skills for dealing with problem families.

Probation and police officers may be advised in their handling of delinquent or sociopathic behavior.

Trade unions and private industry will learn to seek the guidance of the psychiatric specialist about the hiring and firing of the mentally ill and to participate in discussions of psychiatric disability.

Case finding for the mental health center itself will certainly be one result of these activities, but the major goal will be to enhance the capacities of these agencies to deal with the human relations problems of each of them.

FAMILY CARE

Family care requires special mention as a major extramural program of the mental health center. Every community has countless families whose psychological needs demand a warm and tolerant environment for disturbed or retarded children and adults. The social deterioration that chronic institutionalization superimposes on the primary disability is frequently more devastating than illness can ever be.

Social and vocational rehabilitation can be maximal in the framework of a well controlled and supervised foster care program. Public health nurses and/or social workers can make home visits, while the office of the program director can provide individual or group supervision of foster parents and management of patients.

The physical representation of this program is the office of the program director in the administrative section of the Tower.

THE PLAZA

An atmosphere of urban enjoyment has profound mental health implications. The rapid, tense, crowded, utilitarian life of the urban center must have a counterpoint of relaxation, pleasure, and impracticality — in short, of play.

The Plaza will be an area of aesthetic, cultural, and visceral stimulation with universal appeal. It will have the qualities of the Champs Elysees, the Piazza San Marco, Lincoln Center, Coney Island, and the Agora.

Children, of course, have priority on play; it is what gives them the sense of mastery with which to mature. The nursery, a concrete zoo, a carousel, and a pool will be close to the Plaza.

For the family, a Japanese tea garden, a cafe-theater, and a beer garden will be conspicuous parts of the Plaza.

The line between education and pleasure can be very thin, so that an adult educational node will exist on the Plaza.

Families probably will be the dominant unit on evenings and weekends. But the Plaza exists for the lonely, the directionless, and the bizarre, as well. A healthy environment can tolerate deviant behavior, and it is less likely to be destructive deviance when it need not be hidden. Loitering is invited in the Plaza.

The communal expansiveness of the area demands a complement of small, private spaces for individuals and couples to retreat to. A formal garden or an array of arbors will offer an opportunity for quiet and isolation. Sensory stimulation will be minimal. Unlike the Plaza itself, there will be little observing and being observed. The effect will be tranquilizing, if not sedative. Couples and sleepers will find it a haven.

THE NURSERY

The nursery will have close ties to the mental health center. Seventy 3 to 5 year old children can be accommodated at any

one time. These will include the children of mothers who are hospitalized on the inpatient service or at the State Hospital. Other groups of children will attend while their mothers are being treated in the outpatient department, the day care center, or the rehabilitation center.

Children of parents who have no contact with clinical facilities will also be accepted in the nursery.

Apart from the usual benefits of a preschool educational and recreational experience, the nursery will provide the opportunity for a preschool screening for indications of disturbed or retarded behavior among the children. Consultation from the child psychiatry unit will be a regular feature.

THE CENTER FOR URBAN STUDIES

Clinical psychiatry, with its foundation in the medical model and its focus on psychopathology, does not command the breadth of conceptualization necessary to plan for the total needs of a community. Alliances with other disciplines are crucial.

The cultural, recreational, and educational complex that will exist on this site will provide an extraordinary opportunity for social psychologists, educators, economists, anthropologists, city planners, sociologists, lawyers, and philosophers to join forces with the clinicians of the mental health center. Its operations will include on-going, multi-disciplinary seminars, research projects, and problem conferences.

REHABILITATION CENTER

Mental illness thrives on idleness. Twentieth century industrial civilization, however, has little tolerance for the disabled worker. The sheltered workshop provides an atmosphere of productive work without the pressure of highly competitive or automated factories.

On a sub-contractual basis, light industrial and sewing work can be made available to 300 emotionally and physically disabled or mentally retarded individuals. We can conceive of twenty manufacturing units each with fifteen workers and a foreman. Large dining areas will be included as well as office space for foremen, vocational rehabilitation counselors, and group workers.

DOMICILIARY AREA

Near the sheltered workshop will be five independent residences whose occupants will make up about half the manpower pool of the sheltered workshop. These will include:

1. A residence for 20 physically handicapped people who have been evaluated or treated in the Sinai Hospital rehabilitation ward. A nurse and a volunteer will also be housed in the unit.

2. A psychiatric half-way house where 20 ex State Hospital patients will live with two volunteers. (These volunteers may be students from nearby Baltimore Junior College. Their room and board will be free.)

3. A building for Synanon.

4. A residence for 20 trainable retarded children and five staff people.

5. A residence for 50 alcoholic patients and five staff people.

FINANCIAL CONSIDERATION

A mental health operation as broad as this requires a great deal of money. There will be a major coordination of a wide variety of public and private funds.

Federal moneys administered through the National Institute of Mental Health, the Office of Economic Opportunity, and the Housing and Home Finance Agency will be called upon. The projected Department of Urban Affairs would have a direct involvement in many facets of this urban oasis.

The state department of mental health and its rehabilitation commission will be a source of much of the needed money.

The municipal government will participate through the welfare department and the department of parks.

The Center for Urban Studies with its academic focus may have Johns Hopkins and the University of Maryland as its major supports.

A variety of existing private foundations may be appealed to and there is every likelihood that a new foundation devoted to the mental health center will be developed.

Some of the operations of the center will be self-supporting, such as the nursery and the pool, while others may be profitable, such as the apartment and professional suite building, the beer garden, the cabaret-theater, and the small complex of shops.

The center can participate as a United Fund agency and so derive some of its money from the community it directly serves.

EDUCATION

The education of the truly professional person is never complete. Inservice education should be a part of the program plan for all of the service elements of the Community Mental Health Center. The ward, the clinic, the office, or the workbench may each provide the setting for a learning experience. However, more formal recognition of the educational function may be found in unassigned areas of the Bridge and the Tower, where there is ample room for both large and small group meetings, for visual education, and the like.

More elaborate training and teaching programs and projects such as workshops and institutes may be accommodated in the Educational Node.

RESEARCH

Clinical and methodological research can take place in any of the operational areas of the Community Mental Health Center. It should be stimulated, initiated, and coordinated through the administration of the Center. Such research seldom requires substantial floor space.

The Community Mental Health Center, however, has a unique opportunity to become a center for the collection of data, not merely about illness and patients, but also about the gamut of

social problems and the people affected by them. This is the basis for our suggesting the inclusion of a sizeable space for accumulating, processing, and storing such data and complementing offices for analysis and planning corrective social action.

THE INDIVIDUAL

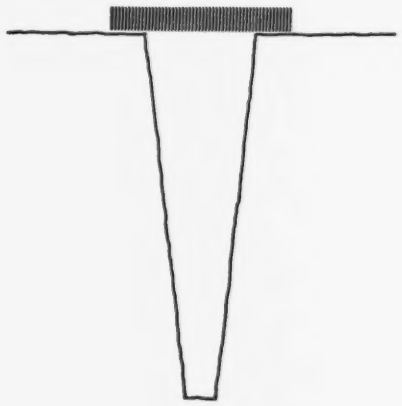
In the structure and function of this mental health center, we have attempted to implement a basically pluralistic philosophy. One of the splendid things about the human condition is its infinite variety. People are different, and their needs are different. A mental health center cannot hope to fulfill the needs of everyone; to impose a rigid system of facilities on a population is not only ineffectual, it is dehumanizing. The goal of psychiatric intervention, in the broadest and most humanistic sense, is to increase the range of human possibility, in short, to augment freedom.

PRIME CONCEPTS

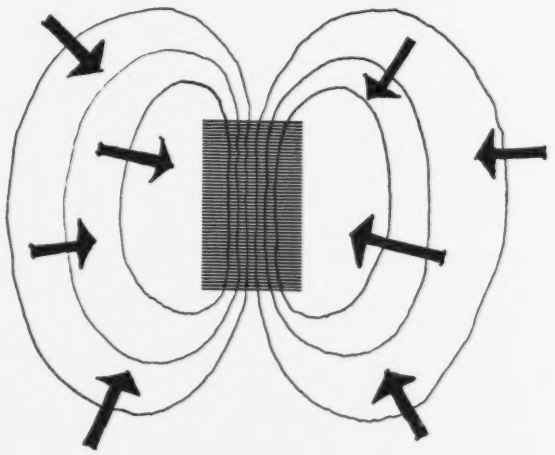
The following are the prime concepts to translate program into architecture.

CONCEPTS

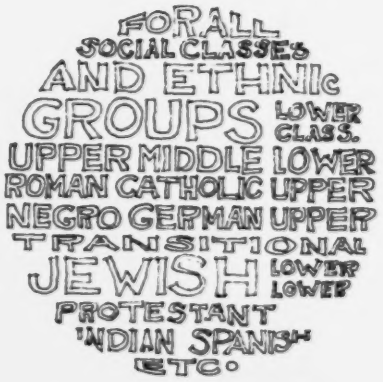
1 THE COMMUNITY MENTAL HEALTH CENTER IS A BRIDGE BETWEEN HOSPITAL AND COMMUNITY, BETWEEN ILLNESS AND HEALTH.



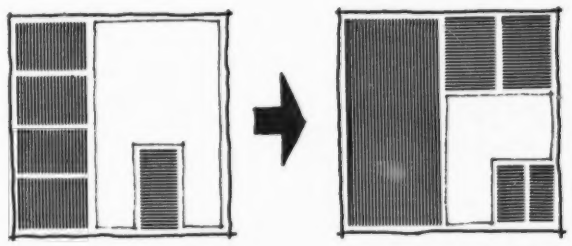
2 THOSE MOST GREATLY IN NEED OF HELP REQUIRE THE GREATEST ENCOURAGEMENT TO SEEK HELP.



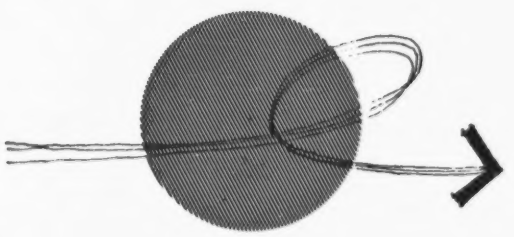
3 THE COMMUNITY MENTAL HEALTH CENTER IS FOR ALL THE PEOPLE.



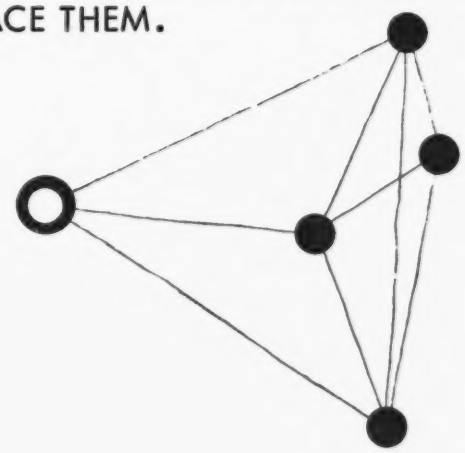
4 PROGRAM REQUIREMENTS ARE BOUND TO CHANGE.



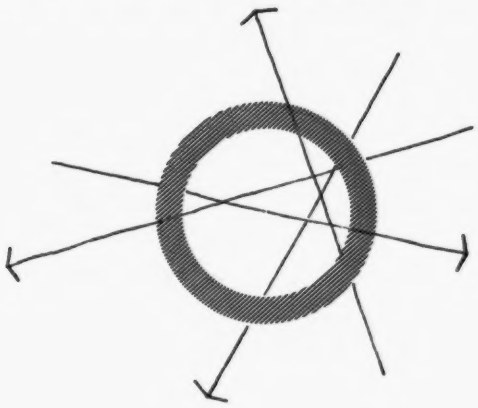
5 THE MENTALLY HEALTHY INDIVIDUAL IS NOT MERELY FREE OF DISEASE; HE IS PRODUCTIVE AND CREATIVE.



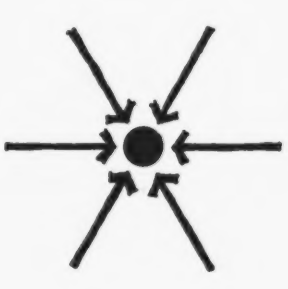
6 THE COMMUNITY MENTAL HEALTH CENTER SHOULD COMPLEMENT EXISTING SERVICES, NOT REPLACE THEM.

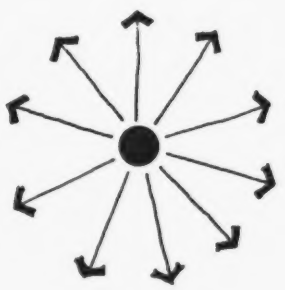


7 THE COMMUNITY MENTAL HEALTH CENTER SHOULD COURT ASSOCIATIONS WITH OTHER PRODUCTIVE, SOCIAL AND CULTURAL AGENCIES.

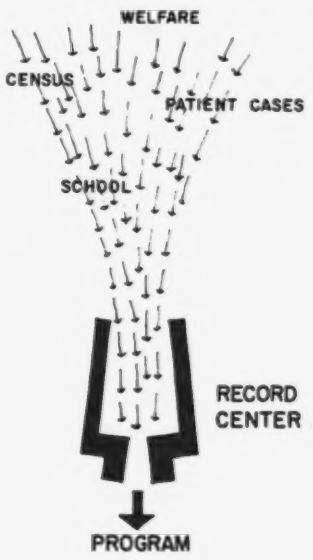


8 MENTAL HEALTH REQUIRES OPPORTUNITY FOR PLAY AND RELAXATION AS A COUNTERPOINT TO THE PRESSURES AND CONSTRICTIONS OF CITY LIFE.

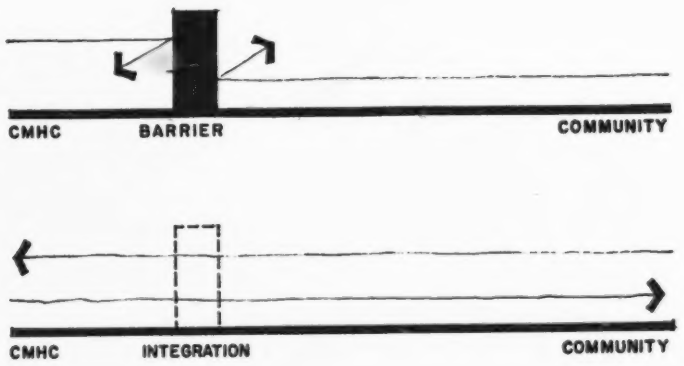




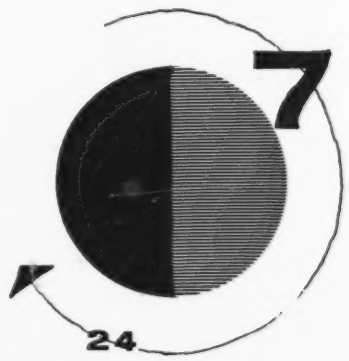
9 MENTAL ILLNESS DOES NOT ENTIRELY RESIDE IN THE INDIVIDUAL; A COMMUNITY MENTAL HEALTH CENTER SHOULD TREAT SOCIAL PROBLEMS AS WELL AS PERSONAL ILLNESS.



10 THERE MUST BE NO WALLS BETWEEN THE MENTAL HEALTH CENTER AND THE COMMUNITY.

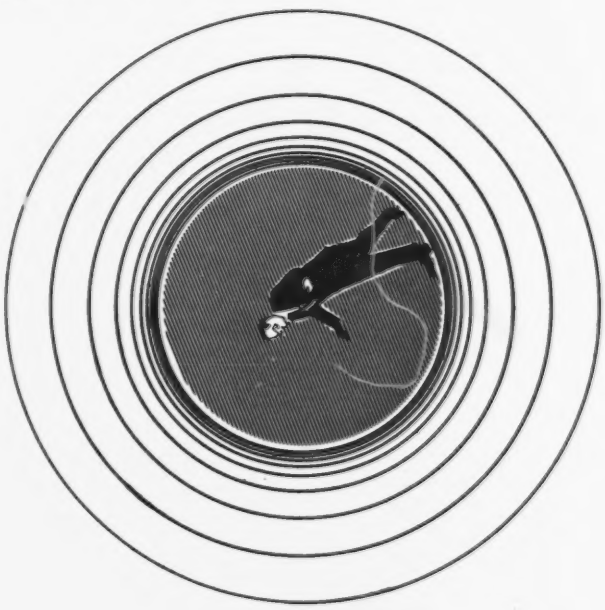


11 PEOPLE WHO NEED HELP NEED IT NOW.

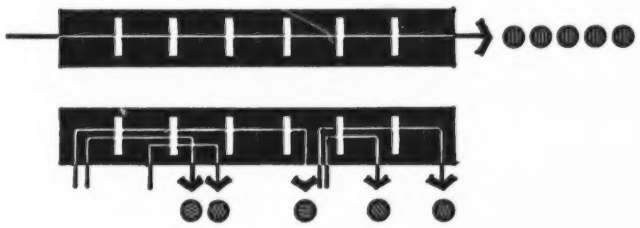


NOCTURNAL ARCHITECTURE

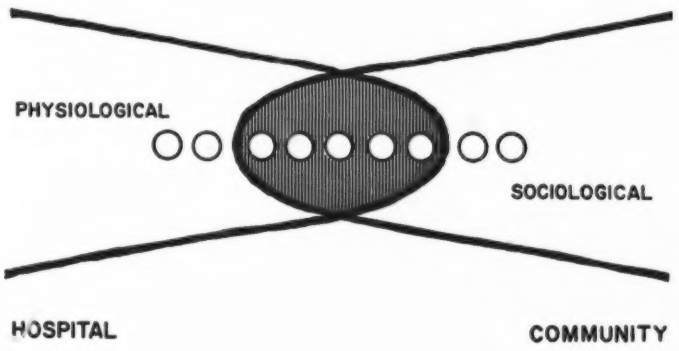
12 THE COMMUNITY MENTAL HEALTH CENTER SHOULD ENHANCE THE CAPACITY OF PEOPLE TO EXPERIENCE LIFE.



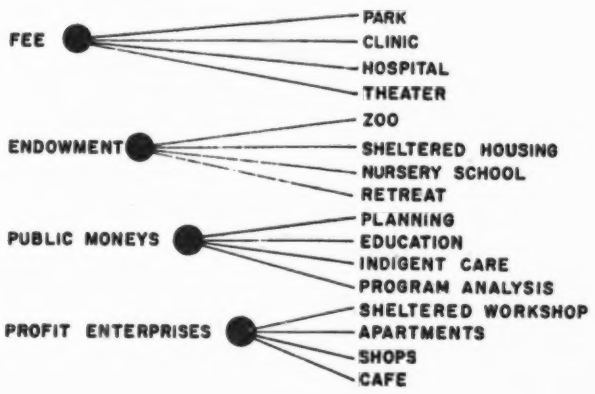
13 THE PROGRAM MUST NOT BE A ONE TRACK ASSEMBLY LINE PROCESS BUT A MULTI TRACK, INDIVIDUALIZED PROCEDURE.



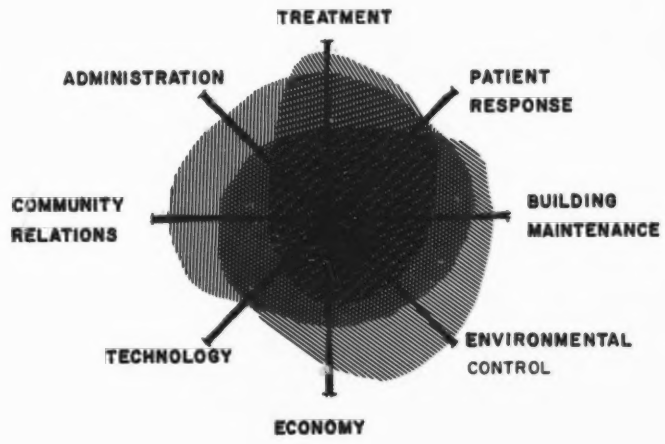
14 THE COMMUNITY AND THE HOSPITAL INTERPENETRATE IN THE SUCCESSFUL COMMUNITY MENTAL HEALTH CENTER.



15 FINANCING OF THE COMMUNITY MENTAL HEALTH CENTER CAN FOLLOW A MULTIPLE RESOURCE PATTERN.



16 PLANNING THE FORM AND FUNCTION OF THE COMMUNITY MENTAL HEALTH CENTER DEMANDS THE TEAMWORK OF ARCHITECTS AND MENTAL HEALTH SPECIALISTS.

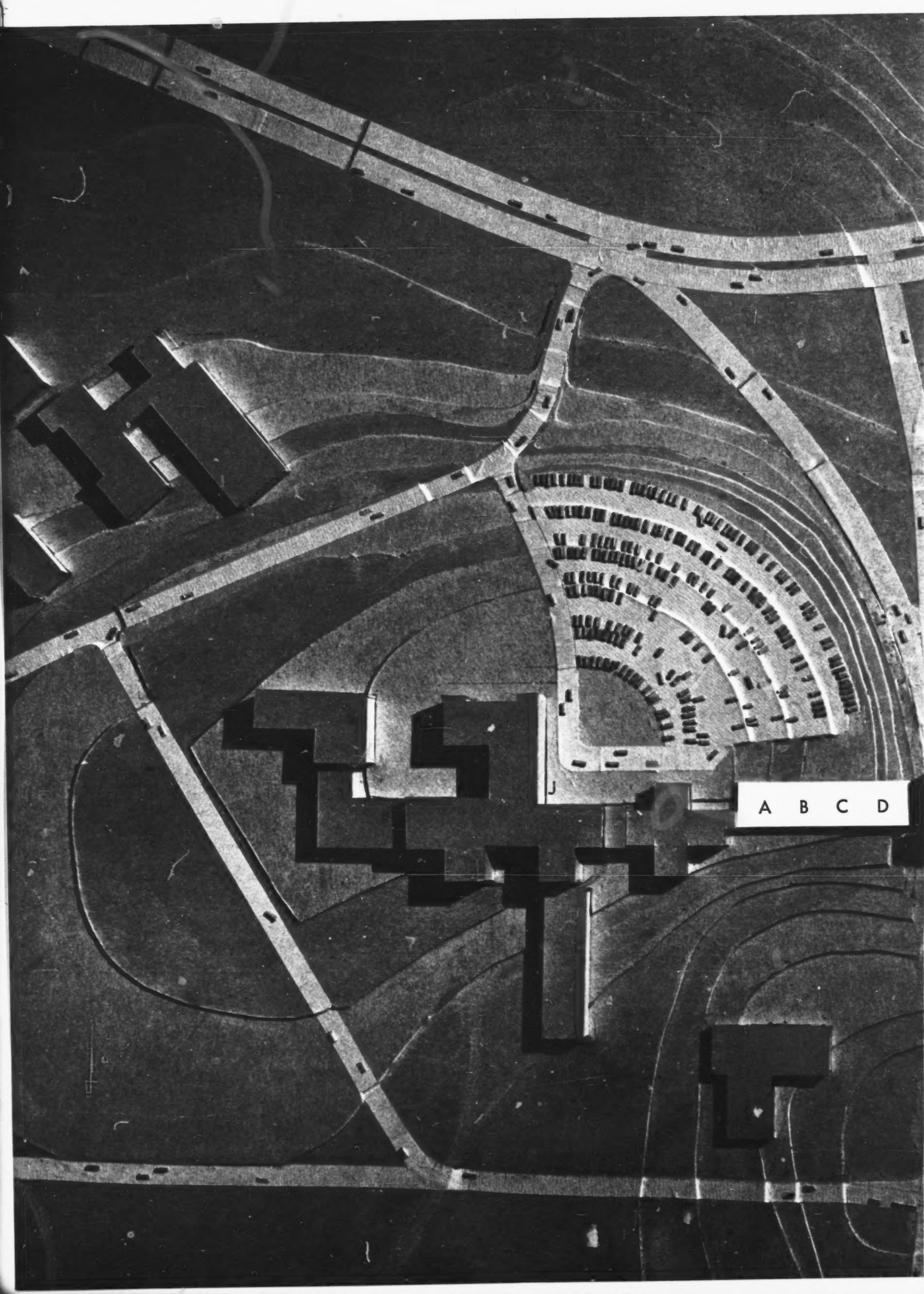


PROGRAMMED SPACES

A Detoxification unit
B Psychiatric ward
C Adult outpatient department
D Child psychiatry department
E The Tower
- Reception
- Administration
  - Planning
  - Education and research
  - Community service
- Triage
- Record center
- Typing pool
- Program analysis
- Center for Urban Studies
- Welfare and community agencies

F The Plaza
G Day and evening center
H Nursery
I Pool
J Psychiatric emergency service
K Sheltered workshop
L Industrial home
- Physically handicapped
- Psychiatric Halfway House
- Home for retarded children
- Domicile for alcoholics
- Synanon

M Concrete zoo
N Carousel
O Cabaret-theater
P Educational node


A B C D

L
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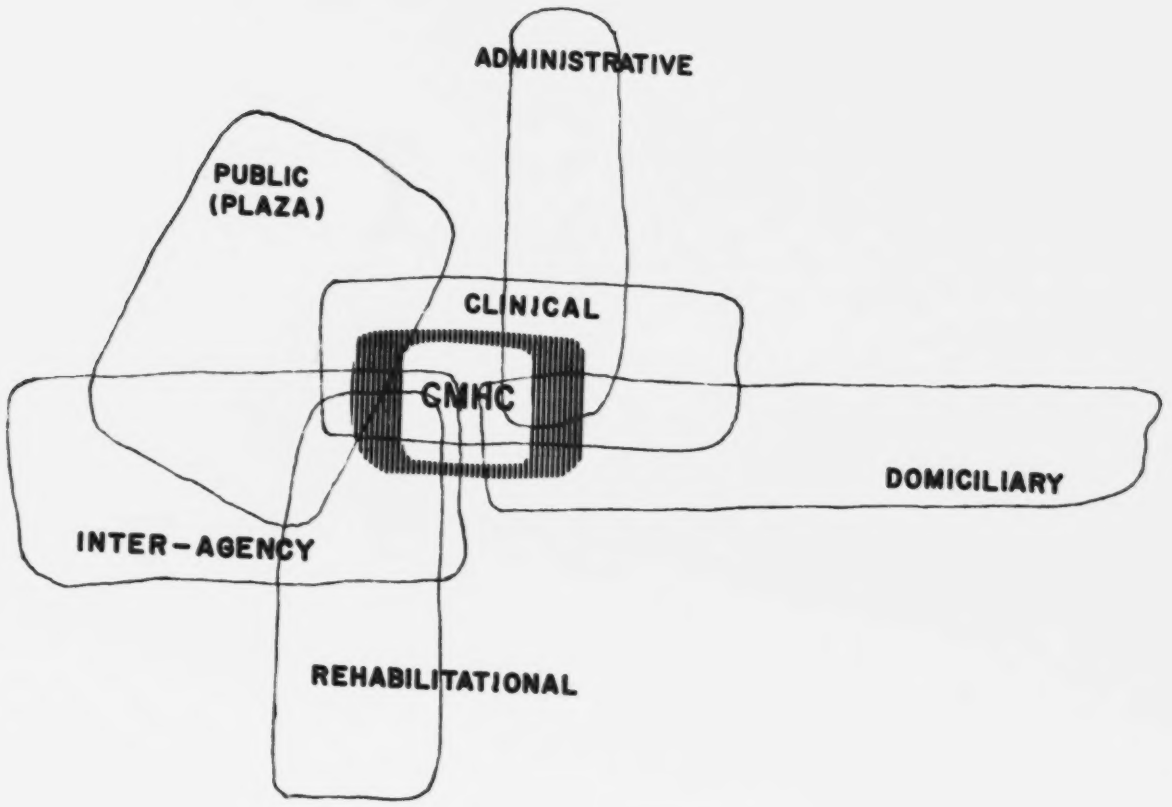
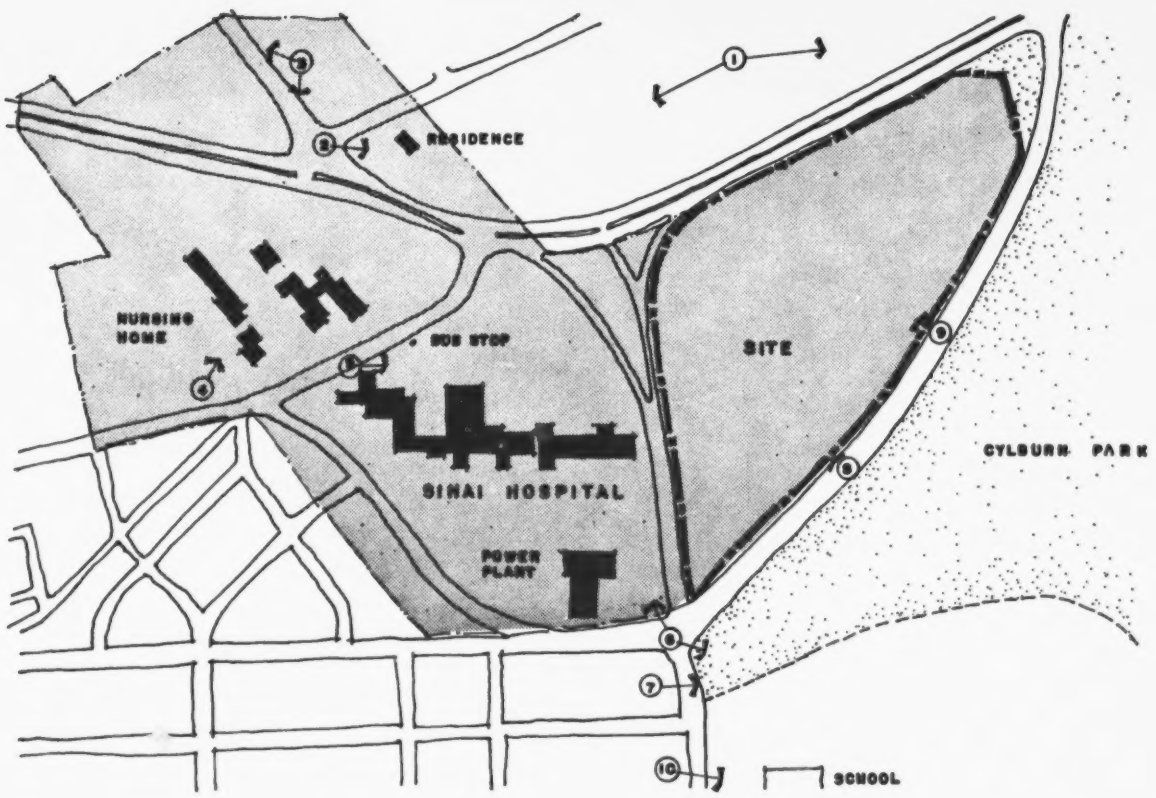
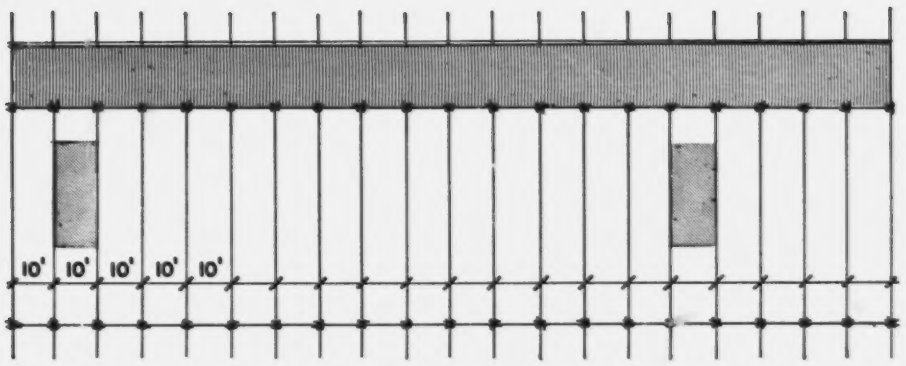
INTERRELATED SERVICES



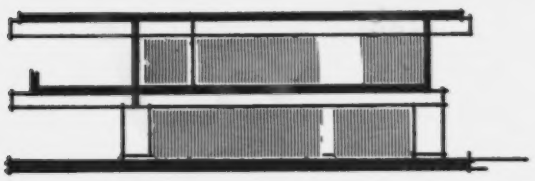
THE SITE



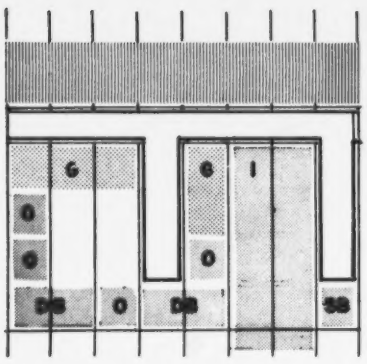
SCHEMATIC PLANS



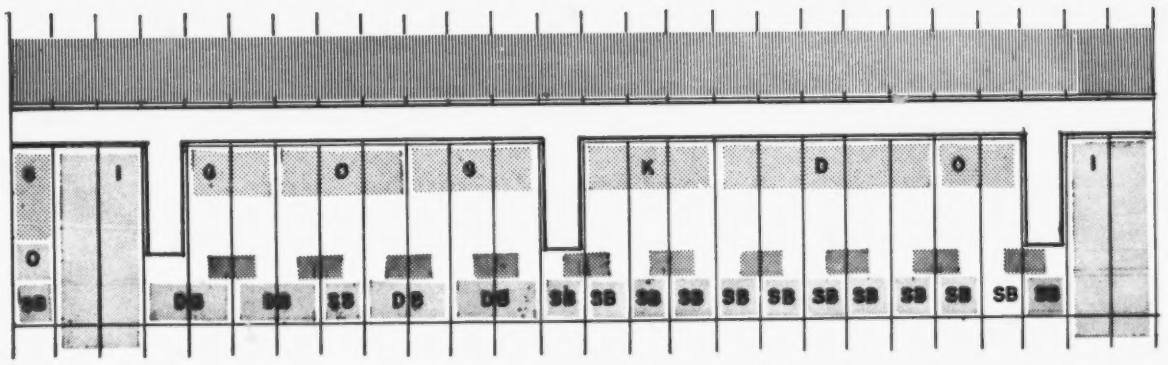
FLEXIBLE LOFT SPACE OF BRIDGE WING



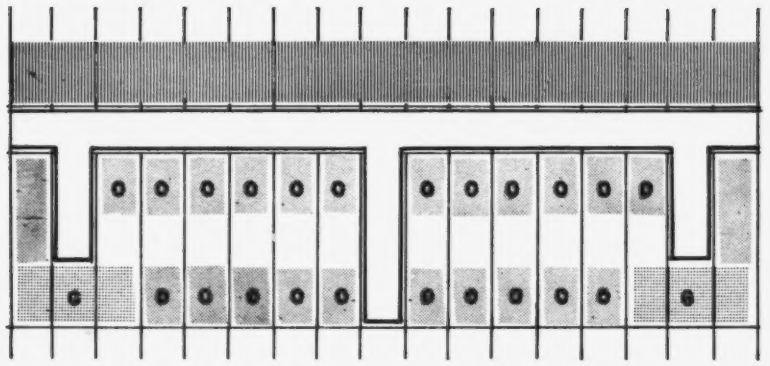
SECTION THROUGH BRIDGE WING



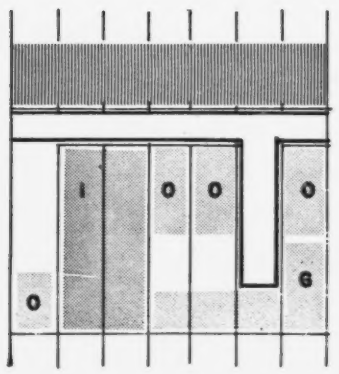
A DETOXIFICATION UNIT



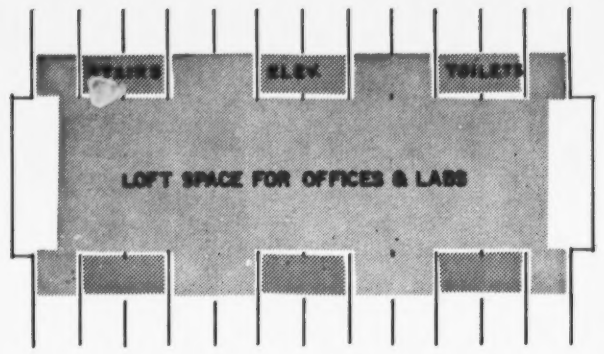
B PSYCHIATRIC WARD



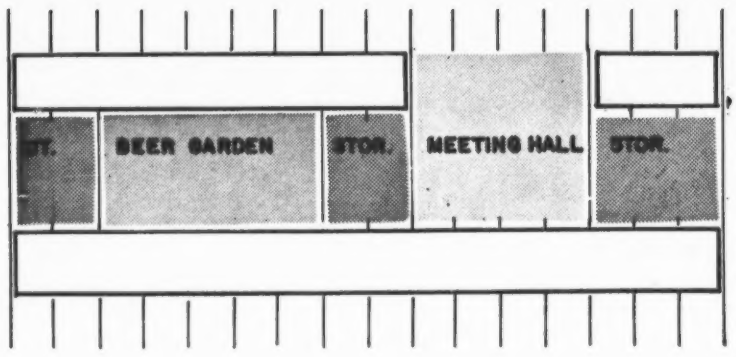
C ADULT OUTPATIENT DEPARTMENT



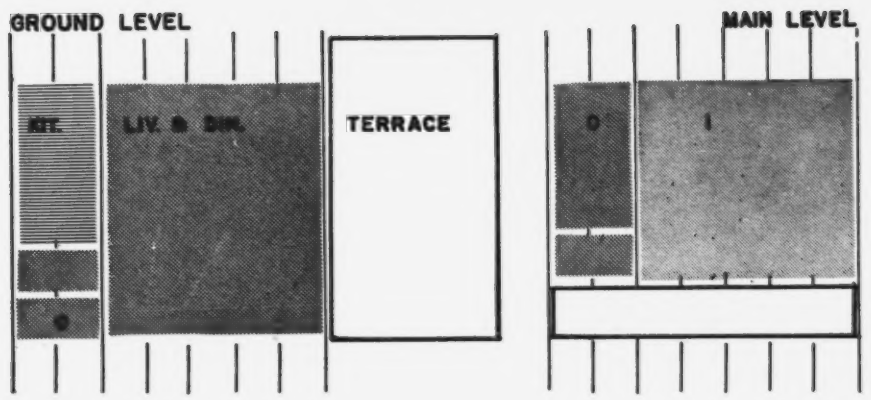
D CHILD PSYCHIATRY DEPARTMENT



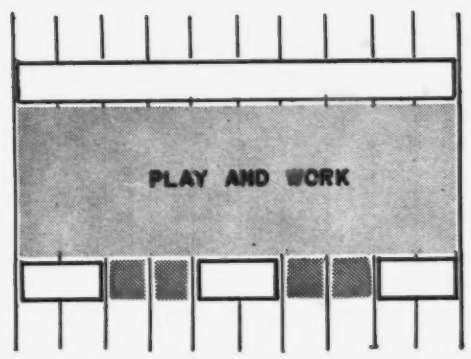
E TYPICAL FLOOR OF THE TOWER



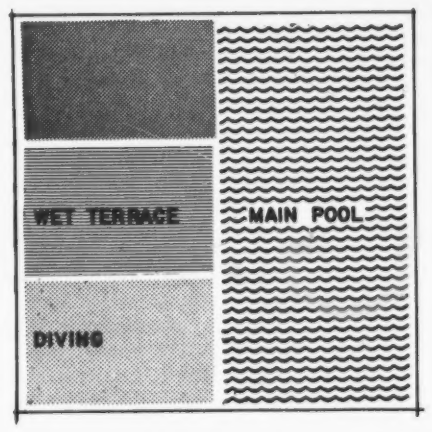
F BUILDING ON THE PLAZA



G DAY AND EVENING CENTER

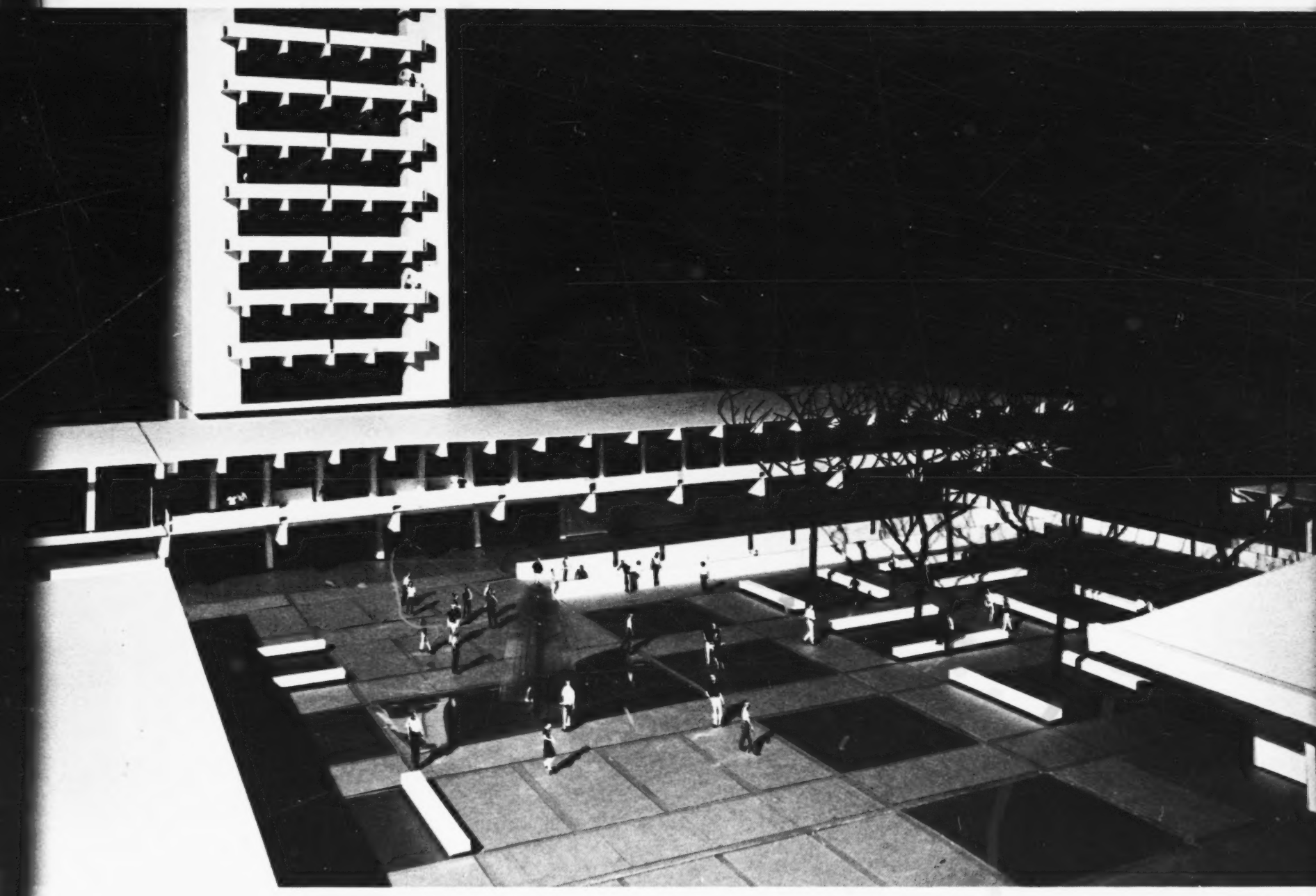


H NURSERY

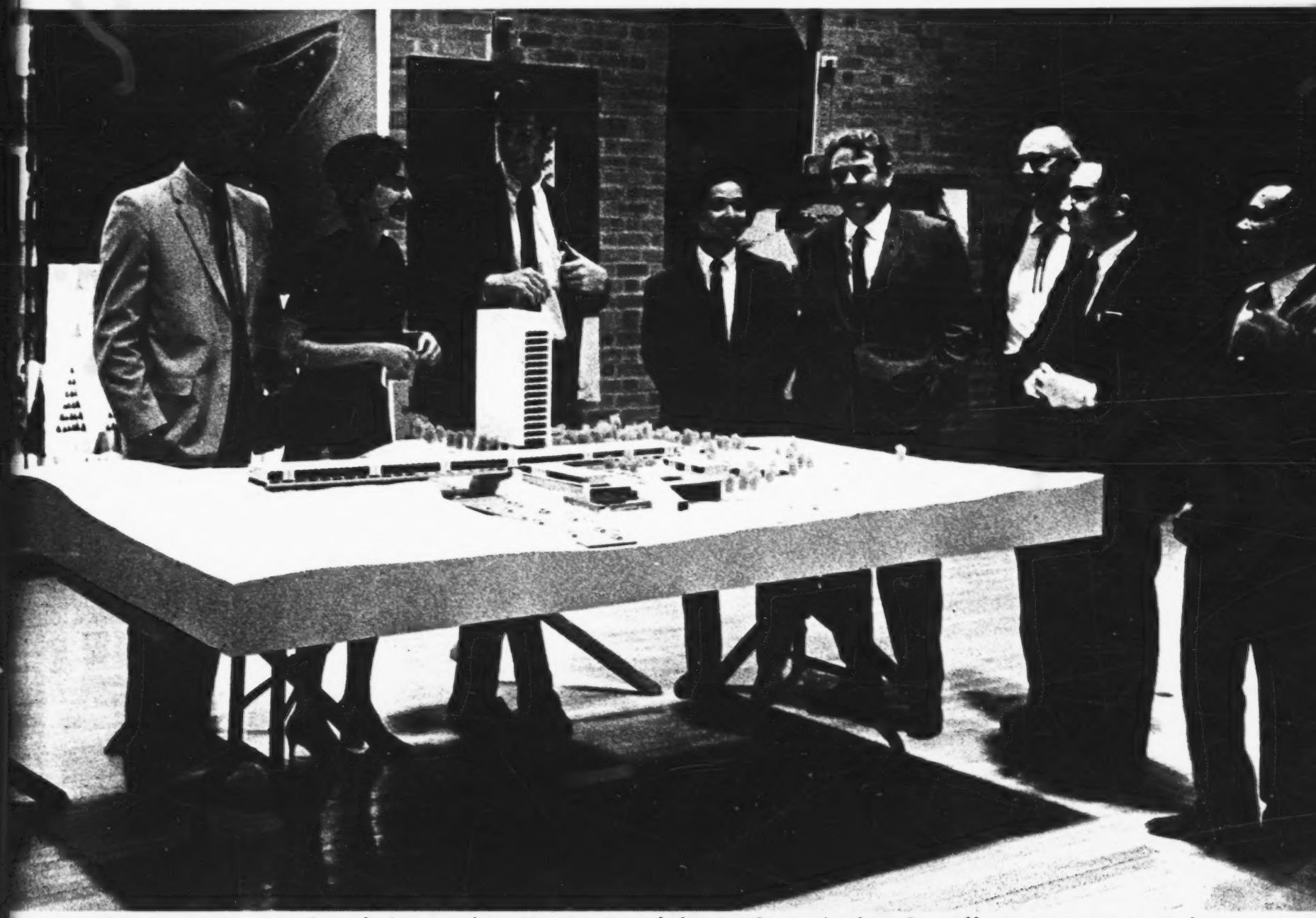


I POOL

A view from the beer garden looking toward the cabaret-theater (right).



This is a look-down view of the Plaza toward the Tower.



The team, reading from left to right: Harris, Rudolph, Redford, Asahi, Caudill, Bay, Dumont, Rahman.

THE TEAM

William W. Caudill, Architect

Alfred Paul Bay, MD, Psychiatrist

Matthew Dumont, MD, Psychiatrist

STUDENTS

James Redford, Captain -- Rice University

Ahsanur Rahman -- Texas A & M (India)

Richard C. Harris -- University of Houston

Tadashi Asahi -- Rice University (Chile)

Alice Rudolph -- Rice University

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